MEDICAL HISTORY

Planned Parenthood®
Care. No matter what.

Name _____ Date _____

I identify as: ☐ Female ☐ Male ☐ Transgender, biologically female ☐ Transgender, biologically male

I prefer to be called: ☐ She ☐ He

These questions may seem personal, but your answers are important to your care. All information will be kept private according to our HIPAA privacy policy.

We want you to know that the staff at Planned Parenthood cares about your safety and can help men and women who have concerns about physical, sexual, or emotional abuse including date rape and domestic violence. We can offer support and resources as part of your visit today.

Please leave any questions that are not applicable blank.

TODAY'S VISIT

What is your **main reason** for today's visit?

☐ I am here for birth control (If you know what birth control method you would like to talk about today, please check it below.)
☐ Long-acting method: IUD ☐ Ring ☐ Long-acting method: Implant ☐ Sterilization ☐ Depo/Shot ☐ Pills
☐ Patch ☐ Condoms and Spermicide ☐ Diaphragm or Cap ☐ Fertility Awareness

☐ I am interested in getting testing: ☐ STD testing ☐ HIV testing ☐ Pregnancy testing

☐ I am here for STD Treatment

☐ I am here for a vaccine/immunization

☐ I am having symptoms

☐ I am here for a well visit

☐ Other reason: _____

When was the **first day** of your last menstrual period? _____ / _____ / _____ ☐ I do not have periods

When was your last Pap test? Month _____ Year _____

If you are over age 40, when was your last mammogram? Month _____ Year _____

MEDICATIONS

List all medications or drugs you are now taking or take often, including prescription medications, birth control, over-the-counter medications, herbal medications, vitamins, minerals, or supplements: _____

☐ I am not currently taking any medications

ALLERGIES

Do you have any allergies to medication? ☐ No ☐ Yes, I'm allergic to: _____
What happens when you take that medication? _____

Are you allergic to latex? ☐ No ☐ Yes
What happens when you come in to contact with latex? _____

PAST MEDICAL HISTORY

Check if you have had any of these conditions in the past:

☐ **I have no past medical conditions** ☐ **I have reviewed and have no new conditions since my last visit**

- ☐ Abnormal Pap
- ☐ Anemia
- ☐ Asthma
- ☐ Benign prostatic hypertrophy (BPH)
- ☐ Bleeding disorder (bleeding too much)
- ☐ Blood transfusion
- ☐ Breast lump
- ☐ Cancer of the breast
- ☐ Lobular carcinoma in situ of the breast
- ☐ Atypical hyperplasia of the breast
- ☐ Thoracic (chest) radiation therapy
- ☐ Cancer of the cervix
- ☐ Cancer, any other type
- ☐ Cancer of the ovary
- ☐ Cancer of the uterus
- ☐ Cerebrovascular accident (stroke)
- ☐ Chlamydia
- ☐ Deep vein thrombosis (DVT) (Blood clot in the vein)
- ☐ Depression
- ☐ DES exposure
- ☐ Diabetes
- ☐ Drug or alcohol abuse
- ☐ Eating disorder
- ☐ Endometriosis
- ☐ Fibroid uterus
- ☐ Fracture of the bone
- ☐ Gallbladder disease
- ☐ Genital herpes
- ☐ Genital warts
- ☐ Gonorrhea
- ☐ Heart failure
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV/AIDS
- ☐ Hypercoagulable Disorder (blood clots too much)
- ☐ Hyperlipidemia (high cholesterol)
- ☐ Hypertension (high blood pressure)
- ☐ Infertility
- ☐ Inflammatory bowel disease
- ☐ Kidney failure
- ☐ Liver disease or tumor
- ☐ Lupus
- ☐ Migraine headaches
- ☐ Myocardial infarction (heart attack)
- ☐ Osteoporosis
- ☐ Pelvic inflammatory disease (PID)
- ☐ Polycystic ovarian syndrome (PCOS)
- ☐ Psychiatric disorder
- ☐ Pulmonary embolus (blood clot in the lung)
- ☐ Seizure or epilepsy
- ☐ Suicide attempt
- ☐ Syphilis
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Recurrent UTIs
- ☐ Recurrent vaginal infections (frequent yeast or BV)
- ☐ Valvular heart disease

PAST SURGERIES

Check the box and write the year if you have had any of these surgeries/procedures:

☐ **I have never had surgery or no new surgeries since my last visit**

- ☐ Appendectomy _____ (appendix removal)
- ☐ Breast implants _____
- ☐ Tubal ligation _____ (female sterilization)
- ☐ Breast biopsy _____
- ☐ Cesarean section _____
- ☐ Cholecystectomy _____ (gallbladder removal)
- ☐ Dilation and curettage (D&C) _____
- ☐ Gastric bypass _____
- ☐ Heart surgery _____
- ☐ Hernia repair _____
- ☐ Hysterectomy _____
- ☐ Liver biopsy _____
- ☐ Mastectomy _____ (breast removal)
- ☐ Breast reduction _____
- ☐ Ovary or fallopian _____ tube removal
- ☐ Other surgery: _____

FAMILY HISTORY

Check which blood relatives (mother, father, brothers, or sisters) in your family have had any of the following illnesses.

☐ **I have no significant family medical history** ☐ **I am adopted or do not know my family medical history**

	Which relative(s)				*Age(s) at onset*
Blood disease	☐ Mother	☐ Father	☐ Brother	☐ Sister	_____
Heart Disease	☐ Mother	☐ Father	☐ Brother	☐ Sister	_____
Cancer	☐ Mother	☐ Father	☐ Brother	☐ Sister	_____
Stroke	☐ Mother	☐ Father	☐ Brother	☐ Sister	_____
Diabetes	☐ Mother	☐ Father	☐ Brother	☐ Sister	_____
High Cholesterol	☐ Mother	☐ Father	☐ Brother	☐ Sister	_____
Hypertension	☐ Mother	☐ Father	☐ Brother	☐ Sister	_____
Osteoporosis (brittle bones)	☐ Mother	☐ Father	☐ Brother	☐ Sister	_____
Kidney disease	☐ Mother	☐ Father	☐ Brother	☐ Sister	_____
Other: _____	☐ Mother	☐ Father	☐ Brother	☐ Sister	_____

IMMUNIZATIONS

These vaccines are a series of 3 shots, check how many of the shots you have received:

Hepatitis B	☐ None	☐ 1 shot	☐ 2 shots	☐ 3 shots
HPV (Gardasil or Cervarix)	☐ None	☐ 1 shot	☐ 2 shots	☐ 3 shots

MENSTRUAL HISTORY

☐ **I am biologically male, this section does not apply (skip to next section)**

How old were you when your period started? _____

How often do you get your period? ☐ More than once a month ☐ Once a month ☐ Less than once a month

Are your periods? ☐ Regular ☐ Irregular How many days does your period usually last? _____

Is your flow? ☐ Light ☐ Moderate ☐ Heavy

SEXUAL HISTORY/STD RISK

Age at first intercourse: _____ ☐ Never had intercourse

Current birth control method(s):
☐ IUD ☐ Implant ☐ Sterilization (tubal, Essure, vasectomy) ☐ Depo/Shot
☐ Pills ☐ Patch ☐ Ring ☐ Condoms ☐ Spermicide ☐ Diaphragm ☐ Breastfeeding
☐ Fertility Awareness ☐ Withdrawal ☐ Menopause ☐ Cervical Cap ☐ None

How many sex partners have you had in the last year? _____

Have you had a new partner in the past 90 days? ☐ No ☐ Yes

Are your partners: ☐ Male ☐ Female ☐ Both

Are your partner's partners: ☐ Male ☐ Female ☐ Both ☐ I don't know

Is your partner monogamous? ☐ No ☐ Yes ☐ I don't know

What kind of sex do you have? ☐ Oral ☐ Vaginal ☐ Anal (receptive) ☐ Anal (insertive)

Do you use condoms: ☐ Always ☐ Sometimes ☐ Never

Have you been exposed to any sexually transmitted diseases (STDs)? ☐ No ☐ Yes ☐ I don't know

Has your partner had symptoms of an infection in the last 60 days? ☐ No ☐ Yes ☐ I don't know

If yes, what symptoms? _____

Have you ever shared needles? ☐ No ☐ Yes

Does your partner use IV drugs? ☐ No ☐ Yes ☐ I don't know

SUBSTANCE USE

Have you ever used street, recreational, or IV drugs? ☐ No ☐ Yes, I've used _____

Do you currently use street, recreational, or IV drugs? ☐ No ☐ Yes, I use _____

Do you use tobacco? ☐ I have never used tobacco ☐ I currently use tobacco ☐ I used to use tobacco, but have quit

If you currently (or used to) use tobacco, what type of tobacco? _____

How much per day? _____ For how many years? _____ What year did you quit using tobacco? _____

Do you drink alcohol? ☐ No ☐ Yes, I drink _____ per day/week

Do you feel you have a problem with drugs or alcohol? ☐ No ☐ Yes, because _____

LIFESTYLE

Do you have any concerns about your weight or eating habits? ☐ No ☐ Yes, I'm concerned about _____

Do you have someone in your life you go to for support? ☐ No ☐ Yes, I go to _____

Do you have a healthy diet? ☐ No ☐ Yes Do you exercise regularly? ☐ No ☐ Yes

Are you currently working? ☐ Full time ☐ Part time ☐ Student ☐ Not working

SYMPTOMS

Check whether you are having any of these symptoms NOW or have them VERY OFTEN:

☐ **I am not having any of these symptoms**

General
- ☐ Weight gain more than 25 pounds
- ☐ Weight loss more than 25 pounds
- ☐ Fever
- ☐ Hot flashes
- ☐ Fatigue/overly tired

Respiratory (lung)
- ☐ Coughing for more than 3 months
- ☐ Shortness of breath
- ☐ Difficulty breathing with exercise
- ☐ Painful breathing
- ☐ Wheezing
- ☐ Spitting up blood

Cardiovascular (heart)
- ☐ Chest pain
- ☐ Irregular heartbeat/ palpitations
- ☐ Syncope (fainting)

GI (stomach)
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea or vomiting
- ☐ Rectal bleeding
- ☐ Bloody stool
- ☐ Involuntary loss of gas or stool

Psychiatric (mental health)
- ☐ Less interest or pleasure in your normal activities
- ☐ Depressed mood
- ☐ Thoughts of suicide
- ☐ I am currently seeing a counselor mental health provider
- ☐ Anxiety

Endocrine
- ☐ Alopecia (hair loss)
- ☐ Intolerance to heat or to cold (much more than normal for you)
- ☐ Excessive hunger, thirst, or urination (much more than normal for you)

Genitourinary (pelvic/vaginal)
- ☐ Pain when you urinate (pee)
- ☐ Leaking urine (pee) (incontinence)
- ☐ Needing to urinate (pee) more often
- ☐ Pain with intercourse or other sexual problems
- ☐ Abnormal vaginal bleeding
- ☐ Vaginal discharge (has changed color, odor, or there is a lot more than normal)
- ☐ Vaginal itching
- ☐ Pelvic pain
- ☐ Severe pain with periods
- ☐ Bleeding or spotting between periods
- ☐ Blood in your urine
- ☐ Incomplete emptying of the bladder
- ☐ Frequent loss of urine (peeing) when you cough or lift
- ☐ Severe PMS

Genitourinary (penis/testicular)
- ☐ Pain when you urinate (pee)
- ☐ Leaking urine (pee) (incontinence)
- ☐ Needing to urinate (pee) much more often
- ☐ Difficult starting to urinate (pee)
- ☐ Decreased urine stream
- ☐ Discharge from the penis
- ☐ Pain in your side(s) or back
- ☐ Pain in the groin area
- ☐ Pain in the scrotum/ testicles
- ☐ Premature ejaculation
- ☐ Erectile dysfunction
- ☐ Feeling the need to urinate (pee) urgently
- ☐ Genital bumps, sores, or rash
- ☐ Blood in your urine
- ☐ Incomplete emptying of the bladder
- ☐ Frequent loss of urine (peeing) when you cough or lift

Skin and breast
- ☐ Rash
- ☐ Skin lesion
- ☐ Breast lump
- ☐ Breast pain
- ☐ Nipple discharge
- ☐ Dry skin
- ☐ Moles (growth or changes)

Neurological (brain)
- ☐ Headache
- ☐ Visual disturbance
- ☐ Weakness
- ☐ Dizziness
- ☐ Seizures
- ☐ Numbness
- ☐ Migraine headaches with aura

Other symptoms ☐ _____ ☐ _____ ☐ _____ ☐ _____

PREGNANCY PLANNING & HISTORY

Have you had any unprotected sex since your last normal period (without using condoms or birth control)? ☐ No ☐ Yes

Emergency contraception can help protect against unintended pregnancy if taken within 120 hours (5 days) after unprotected sex.

Are you or your partner planning a pregnancy in the next year? ☐ No ☐ Yes

Pregnancy history: ☐ Never pregnant (skip to the next section) ☐ Currently pregnant

How many times have you been pregnant? _____ # of births _____ # of miscarriages _____ # of abortions _____

# of ectopics (tubal pregnancies) _____ # of living children _____ # of c-sections ____

Are you currently breastfeeding? ☐ No ☐ Yes

Age at first pregnancy: _____ Age at your last pregnancy: _____

Any problems with pregnancy, birth, or abortion? ☐ No ☐ Yes

If yes, please describe the problem(s): _____

BREAST CANCER RISK SCREENING

Some women and men may be at higher risk for developing breast cancer based on personal and family history. These questions can help determine if you are at increased risk.

Have any of your blood relatives ever been diagnosed with:

Breast cancer ☐ No ☐ Yes If yes, please explain: _____

Ovarian cancer ☐ No ☐ Yes If yes, please explain: _____